The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage visit www.iuhealthplans.org or call 1-866-895-5975. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-877-267-2323 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: $2,600 employee-only / $5,200 all other coverage levels. Out-of-Network: No Coverage	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. The deductible starts over each January 1st.
Are there services covered before you meet your deductible?	Yes	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $3,200 employee-only / $6,400 all other coverage levels Out-of-Network: No Coverage	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums; balance-billing charges; out-of-network transplants; and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider:	Yes. See www.iuhealthplans.org or call 1-866-895-5975 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat injury or illness	20% coinsurance	Not Covered	None
	Specialist visit	20% coinsurance	Not Covered	Chiropractic care is limited to 12 manipulations per plan year.
	Preventive care / screening / immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are considered and will be billed as preventive care.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	Preauthorization required
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	Preauthorization required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs	20% coinsurance	Not Covered	Deductible does not apply to preventive prescriptions. Covers up to 30-day supply at Retail; 90-day supply through Mail-Order for in-network providers. Mail-Order is limited to only in-network providers.
	Preferred brand drugs	20% coinsurance	Not Covered	
	Non-preferred brand drugs	20% coinsurance	Not Covered	
	Specialty drugs	20% coinsurance	Not Covered	Coverage limited to in-network mail order only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	20% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance	Paid as in-network if an emergency.	Non-emergency care is not covered in an emergency room.
	Emergency medical transportation	20% coinsurance	Paid as in-network if an emergency.	None
	Urgent care	20% coinsurance	Paid as in-network if more than 50 miles from home.	None

If you have a hospital stay	Facility fee (e.g. hospital room)	20% coinsurance	Not Covered	Preauthorization required
	Physician/surgeon fees	20% coinsurance	Not Covered	Preauthorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not Covered	Treatment plan required after 10 visits
	Inpatient services	20% coinsurance	Not Covered	Preauthorization required
If you are pregnant	Office visits	20% coinsurance	Not Covered	None
	Childbirth/delivery professional services	20% coinsurance	Not Covered	None
	Childbirth/delivery facility services	20% coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Preauthorization required. Unlimited In-Network visits and 30 visits Out-of-Network.
	Rehabilitation services	20% coinsurance	Not Covered	Outpatient limits: Physical Therapy 60 visits/year, Occupational Therapy 60 visits/year, Speech Therapy 20 visits/year.
	Habilitation services	20% coinsurance	Not Covered	Habilitation visits count towards your rehabilitation limit.
	Skilled nursing care	20% coinsurance	Not Covered	Preauthorization required
	Durable medical equipment	20% coinsurance	Not Covered	See plan booklet
	Hospice service	20% coinsurance	Not Covered	Preauthorization required
If your child needs dental or eye care	Eye exam	$10 copayment	$42 allowance	Limit of one exam per year
	Glasses	Varies	Varies	None
	Dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Infertility treatment
- Routine foot care
- Cosmetic surgery
- Long-term care
- Weight loss programs
- Private duty nursing (rendered in a hospital or skilled nursing facility)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric survery
- Hearing aides (Adults 18 or over)
- Chiropractic care (12 visits/year)
- Routine eye care (Adult) – EyeMed Vision
- Private duty nursing as part of covered home health care

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-800-873-2022, fax 812-314-2543, IU Health Plans, Office of Appeals, P.O. Box 627, Columbus, Indiana 47202-0627 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage? Yes. If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes. If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-736-0920.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-736-0920.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-844-736-0920.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-736-0920.
Korean (**한국어**): 한국어로 전화를하려면이 번호로 전화하십시오 1-844-736-0920.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible: $2,600
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,**731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,600
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
Total Peg would pay is	$3,**260**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible: $2,600
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment *(glucose meter*)

Total Example Cost	$7,**389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,600
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$55
Total Joe would pay is	$**3,255**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

- The plan's overall deductible: $2,600
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$1,9**25**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,925
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
Total Mia would pay is	$1,9**25**

The plan would be responsible for the other costs of these EXAMPLE covered services.